FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037317

Facility Name: Lexington of Elmhurst

Address: 420 W. Butterfield Road (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630) 832-2300 **Fax #** (630) 832-7043

IDPA ID Number: 363682838001

Date of Initial License for Current Owners: 11/12/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	148	Skilled (SNF)	148	54,168	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	148	TOTALS	148	54,168	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,182	5,757	6,041	26,980	8
9	SNF/PED					9
10	ICF	9,417	10,783	232	20,432	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,599	16,540	6,273	47,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.53%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 5,675

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	271,246	25,105	9,000	305,351		305,351		305,351			1
2	Food Purchase		202,873		202,873		202,873	(9,433)	193,440			2
3	Housekeeping	198,974	22,438		221,412		221,412		221,412			3
4	Laundry	47,102	20,343		67,445		67,445	(3,514)	63,931			4
5	Heat and Other Utilities			161,010	161,010		161,010	1,504	162,514			5
6	Maintenance	51,835		84,105	135,940		135,940	2,203	138,143			6
7	Other (specify):*											7
8	**TOTAL General Services**	569,157	270,759	254,115	1,094,031		1,094,031	(9,240)	1,084,791			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,865,201	132,458	16,431	2,014,090		2,014,090		2,014,090			10
10a	Therapy			448,748	448,748		448,748		448,748			10a
11	Activities	133,848	18,015	3,416	155,279		155,279	11	155,290			11
12	Social Services	47,782		2,026	49,808		49,808		49,808			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,046,831	150,473	476,621	2,673,925		2,673,925	11	2,673,936			16
	C. General Administration											
17	Administrative	114,776		297,565	412,341		412,341	(297,565)	114,776			17
18	Directors Fees											18
19	Professional Services			38,619	38,619		38,619	(3,179)	35,440			19
20	Dues, Fees, Subscriptions & Promotions			32,160	32,160		32,160	2,850	35,010			20
21	Clerical & General Office Expenses	239,255	27,520	19,676	286,451		286,451	12,161	298,612			21
22	Employee Benefits & Payroll Taxes			311,622	311,622		311,622	39,067	350,689			22
23	Inservice Training & Education							186	186			23
24	Travel and Seminar			1,493	1,493		1,493	267	1,760			24
25	Other Admin. Staff Transportation			53	53		53	5,849	5,902			25
26	Insurance-Prop.Liab.Malpractice			29,379	29,379		29,379	1,194	30,573			26
27	Other (specify):*											27
28	**TOTAL General Administration**	354,031	27,520	730,567	1,112,118		1,112,118	(239,170)	872,948			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,970,019	448,752	1,461,303	4,880,074		4,880,074	(248,399)	4,631,675			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of Elmhurst #0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			23,392	23,392		23,392	152,839	176,231			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							267,017	267,017			32
33	Real Estate Taxes							64,607	64,607			33
34	Rent-Facility & Grounds			843,573	843,573		843,573	(843,573)				34
35	Rent-Equipment & Vehicles			1,745	1,745		1,745	255	2,000			35
36	Other (specify):*											36
37	**TOTAL Ownership**			868,710	868,710		868,710	(358,855)	509,855			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,399	5,531	121,930		121,930		121,930			39
40	Barber and Beauty Shops			29,346	29,346		29,346		29,346			40
41	Coffee and Gift Shops			1,376	1,376		1,376		1,376			41
42	Provider Participation Fee			81,252	81,252		81,252		81,252			42
43	Other (specify):* Nonallowable costs			41,066	41,066		41,066	(41,066)				43
44	**TOTAL Special Cost Centers**		116,399	158,571	274,970		274,970	(41,066)	233,904			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,970,019	565,151	2,488,584	6,023,754		6,023,754	(648,320)	5,375,434			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(48)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,514)	4		8
9	Non-Straightline Depreciation	1,692	30		9
10	Interest and Other Investment Income	(13,614)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,074)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,280)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,826)	43		24
25	Fund Raising, Advertising and Promotional	(4,886)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(6,996)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,546)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(584,774)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (584,774)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (648,320)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Elmhurst		
James Samatas	16.66%			II Ltd. Ptsp.	Elmhurst	Real estate ptsp.
John Samatas	16.67%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
Cynthia Thiem	16.67%	See attached Schedule B		Lexington Financial		
Jeffrey Bell, James Bell Declaration of				Services L.L.C. II	Lombard	Finance Co.
Trust, Larry Bell and David Bell	50.00%					
each owning 12.5%						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 843,573	Sambell of Elmhurst II Limited Partnership	**	$	$ (843,573)	1
2	V	30	Depreciation		Sambell of Elmhurst II Limited Partnership	**	142,853	142,853	2
3	V	32	Interest expense		Sambell of Elmhurst II Limited Partnership	**	276,836	276,836	3
4	V	32	Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	2,429	2,429	4
5	V	33	Property taxes		Sambell of Elmhurst II Limited Partnership	**	63,573	63,573	5
6	V	21	Miscellaneous		Sambell of Elmhurst II Limited Partnership	**	90	90	6
7	V	21	Bank charges		Sambell of Elmhurst II Limited Partnership	**	85	85	7
8	V	19	Professional fees		Sambell of Elmhurst II Limited Partnership	**	65	65	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 843,573			$ 485,931	$ * (357,642)	14

** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Sambell of Elmhurst II Limited Partnership

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	**	$ 15,971	$ 15,971	15
16	V	22	FUTA		Royal Management Corp.	**	332	332	16
17	V	22	SUTA		Royal Management Corp.	**	890	890	17
18	V	22	Insurance - W/C		Royal Management Corp.	**	188	188	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**	8,077	8,077	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**	4,224	4,224	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,659	2,659	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	1,477	1,477	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**	4,158	4,158	23
24	V	33	Property taxes		Royal Management Corp.	**	1,034	1,034	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**	852	852	25
26	V	26	Insurance - general		Royal Management Corp.	**	1,194	1,194	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**	385	385	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**	1,256	1,256	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**	248	248	29
30	V	11	Activities Consultant		Royal Management Corp.	**	11	11	30
31	V	35	Equipment rental		Royal Management Corp.	**	255	255	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	2,461	2,461	32
33	V	25	Auto expense		Royal Management Corp.	**	5,849	5,849	33
34	V	21	Bank charges		Royal Management Corp.	**	185	185	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**	3,620	3,620	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**	389	389	36
37	V	21	Office supplies & printing		Royal Management Corp.	**	4,697	4,697	37
38	V	21	Postage		Royal Management Corp.	**	1,753	1,753	38
39	Total			$			$ 62,165	$ * 62,165	39

** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	**	$ 847	$ 847	15
16	V	6	Security service		Royal Management Corp.	**	9	9	16
17	V	21	Telephone		Royal Management Corp.	**	5,014	5,014	17
18	V	21	Communications		Royal Management Corp.	**	360	360	18
19	V	24	Travel & seminar		Royal Management Corp.	**	486	486	19
20	V	32	Interest		Royal Management Corp.	**	1,366	1,366	20
21	V	23	Training & education		Royal Management Corp.	**	186	186	21
22	V	17	Management fees	297,565	Royal Management Corp.	**		(297,565)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 297,565			$ 8,268	$ * (289,297)	39

** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	16.66%	See Schedule C	3	6%	Salary	$ 18,538	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	16.67%	See Schedule C	1	2%	Salary	8,238	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	16.67%	See Schedule C	1	3%	Salary	10,300	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	2%	Salary	3,296	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2	5%	Salary	5,478	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 45,850		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	54,168	$ 15,971	1
2	22	FUTA	Bed Days	788,945	11	4,830		54,168	332	2
3	22	SUTA	Bed Days	788,945	11	12,967		54,168	890	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		54,168	188	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		54,168	8,077	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		54,168	4,224	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		54,168	2,659	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		54,168	1,477	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		54,168	4,158	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		54,168	1,034	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		54,168	852	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		54,168	1,194	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		54,168	385	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		54,168	1,256	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		54,168	248	15
16	11	Activity consultant	Bed Days	788,945	11	167		54,168	11	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		54,168	255	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		54,168	2,461	18
19	25	Auto expense	Bed Days	788,945	11	85,184		54,168	5,849	19
20	21	Bank charges	Bed Days	788,945	11	2,695		54,168	185	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		54,168	3,620	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		54,168	389	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		54,168	4,697	23
24	21	Postage	Bed Days	788,945	11	25,535		54,168	1,753	24
25	TOTALS					$ 905,395	$		$ 62,165	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	54,168	$ 847	1
2	6	Security Service	Bed Days	788,945	11	127		54,168	9	2
3	21	Telephone	Bed Days	788,945	11	73,022		54,168	5,014	3
4	21	Communications	Bed Days	788,945	11	5,248		54,168	360	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		54,168	486	5
6	32	Interest	Bed Days	788,945	11	19,899		54,168	1,366	6
7	23	Training & Education	Bed Days	788,945	11	2,716		54,168	186	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 8,268	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial Services,						$	$			$	1
2	L.L.C. II	x		Mortgage	Varies	12/29/98	4,256,000	4,049,845	1/2008	0.0675	276,836	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,256,000	$ 4,049,845			$ 276,836	9
	B. Non-Facility Related*											
10								Amortization of loan costs			2,429	10
11								Interest income offset			(13,614)	11
12								Allocated from management company			1,366	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,819)	14
15	TOTALS (line 9+line14)						$ 4,256,000	$ 4,049,845			$ 267,017	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 66,000	1
	Allocated from Management Company	1,034	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 63,573	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,393)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 64,607	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	59,371	8
1996	60,059	9
1997	62,018	10
1998	62,599	11
1999	63,573	12

1999 taxes:	63,573
Estimated increase (4%):	1.04
Estimated 2000 taxes:	66,116
Use:	66,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lexington Square Life Care of Elmhurst, Inc.; Continuing Care Retirement Community; 348 units; 485,300 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	55,000	1991	$ 1,277,670	1
2					2
3	TOTALS	55,000		$ 1,277,670	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 1,071,474	4
5	10		1995	1995	73,302	2,095	35	2,095		11,848	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1992	693	20	35	20		164	9
10	Land Improvement			1995	7,500	500	15	500		2,667	10
11	Fan Coil Units			1996	4,903	140	35	140		630	11
12	Patio			1996	2,322	155	15	155		697	12
13	Basement rehab			1997	17,151	1,715	10	1,715		5,860	13
14	Baseboards			1997	3,129	313	10	313		1,017	14
15	Wiring			1998	3,090	309	10	309		773	15
16	Lobby Tile			1999	19,354	1,935	10	1,935		3,709	16
17	Patio			1999	4,196	280	15	280		280	17
18	Automatic Door			2000	1,300	65	10	65		65	18
19	Wallpaper			2000	6,853	343	10	343		343	19
20	Patio			2000	1,242	41	15	41		41	20
21	Storage closet for HVAC			2000	3,745	125	15	125		125	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,259,366	$ 8,036		$ 125,481	$ 117,445	$ 1,099,693	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from management company			1995	6,989		35	215	215	1,098	9
10	Allocated from management company			1996	5,688		35	175	175	731	10
11	Allocated from management company			1989	196		31	6	6	80	11
12	Allocated from management company - HVAC			1998	147		35	5	5	13	12
13	Allocated from management company - Offices			1999	372		35	12	12	16	13
14	Allocated from management company - Offices			2000	176		35	5	5	4	14
15	Allocated from management company			1987	32,671		31	1,010	1,010	13,271	15
16	Allocated from management company			1993	17		39	1	1	3	16
17	Allocated from management company			1995	736		39	23	23	103	17
18	Allocated from management company			1996	147		39	5	5	16	18
19	Allocated from management company - Sidewalk			1998	308		39	10	10	19	19
20	Allocated from management company - Roof			1998	11		15	1	1	3	20
21	Allocated from management company - Awnings			1999	190		39	6	6	28	21
22	Allocated from management company - Parking lot			1999	87		15	3	3	3	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 47,735	$		$ 1,477	$ 1,477	$ 15,388	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 364,824	$ 14,534	$ 41,634	$ 27,100	5-10 years	$ 292,495	37
38	Current Year Purchases	8,791	822	822		5-10 years	822	38
39	Fully Depreciated Assets	8,227					8,227	39
40	Allocated from Management Company	40,966		4,158	4,158		28,991	40
41	TOTALS	$ 422,808	$ 15,356	$ 46,614	$ 31,258		$ 330,535	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43	Allocated from Management Company			17,749		2,659	2,659		10,908	43
44										44
45										45
46	TOTALS			$ 17,749	$	$ 2,659	$ 2,659		$ 10,908	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,025,328	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 23,392	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 176,231	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 152,839	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,456,524	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,000 Description: Postage Meter - $708; Copier - $1,037; Allocated from Management Company - $255
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	15,265	$ 196,289	$	15,265	$ 196,289	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		1,398	16,543		1,398	16,543	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		20,577	235,916		20,577	235,916	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				106,607		106,607	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Oxygen Other (specify): Clinitron Bed & Lab	L 39, C 2 L 39, C 3				5,531	9,792		9,792 5,531	13
14	TOTAL			$	37,240	$ 454,279	$ 116,399	37,240	$ 570,678	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 308,536	$ 316,533	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 201,769)	1,483,399	1,483,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,790	18,790	6
7	Other Prepaid Expenses	413	413	7
8	Accounts Receivable (owners or related parties)	43,916	43,916	8
9	Other(specify): Escrow		27,827	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,855,054	$ 1,890,878	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,454	3,454	12
13	Land		1,277,670	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	148,780	196,515	15
16	Equipment, at Historical Cost	110,848	440,557	16
17	Accumulated Depreciation (book methods)	(84,049)	(1,456,524)	17
18	Deferred Charges		862	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized loan costs		43,730	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 179,033	$ 4,616,850	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,034,087	$ 6,507,728	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 249,295	$ 249,295	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,100	159,100	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,611	2,611	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,000	32
33	Accrued Interest Payable		22,780	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	139,307	56,970	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 550,313	$ 556,756	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,049,845	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,049,845	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 550,313	$ 4,606,601	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,483,774	$ 1,901,127	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,034,087	$ 6,507,728	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,537,529	1
2	Restatements (describe):		2
3	**Prior year post closing entries**	(104,570)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,432,959	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,610,815	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,560,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 50,815	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,483,774	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,276,333	1
2	Discounts and Allowances for all Levels	(709,065)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,567,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	793,770	6
7	Oxygen	525	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 794,295	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	338	12
13	Barber and Beauty Care	36,854	13
14	Non-Patient Meals	48	14
15	Telephone, Television and Radio	12	15
16	Rental of Facility Space		16
17	Sale of Drugs	125,638	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,227	19
20	Radiology and X-Ray		20
21	Other Medical Services	84,738	21
22	Laundry	3,514	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 259,369	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,288	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,288	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	1,349	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,349	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,634,569	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,094,031	31
32	Health Care	2,673,925	32
33	General Administration	1,112,118	33
	B. Capital Expense		
34	Ownership	868,710	34
	C. Ancillary Expense		
35	Special Cost Centers	193,718	35
36	Provider Participation Fee	81,252	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,023,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,610,815	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,610,815	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,532	1,712	$ 47,319	$ 27.64	1
2	Assistant Director of Nursing	1,123	1,201	27,247	22.69	2
3	Registered Nurses	30,107	32,275	769,988	23.86	3
4	Licensed Practical Nurses	8,567	8,988	169,789	18.89	4
5	Nurse Aides & Orderlies	68,921	71,391	717,157	10.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,026	11,789	133,701	11.34	8
9	Activity Director	1,899	1,951	21,867	11.21	9
10	Activity Assistants	13,158	13,587	111,981	8.24	10
11	Social Service Workers	4,058	4,187	47,782	11.41	11
12	Dietician	136	144	2,946	20.46	12
13	Food Service Supervisor	2,007	2,087	31,451	15.07	13
14	Head Cook	1,726	1,924	19,773	10.28	14
15	Cook Helpers/Assistants	17,660	18,456	152,674	8.27	15
16	Dishwashers	9,803	10,257	64,402	6.28	16
17	Maintenance Workers	3,642	3,931	51,835	13.19	17
18	Housekeepers	29,415	30,641	198,974	6.49	18
19	Laundry	7,518	7,810	47,102	6.03	19
20	Administrator	1,874	2,128	68,926	32.39	20
21	Assistant Administrator					21
22	Other Administrative	445	457	45,850	100.33	22
23	Office Manager					23
24	Clerical	15,340	16,229	239,255	14.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	229,957	241,145	$ 2,970,019 *	$ 12.32	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,000	L 1, C 3	35
36	Medical Director	Monthly	6,000	L 9, C 3	36
37	Medical Records Consultant	13	625	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,416	L 11, C 3	44
45	Social Service Consultant	Monthly	2,026	L 12, C 3	45
46	Other(specify)				46
47	Utilization Review	3	225	L 10, C 3	47
48					48
49	TOTAL (lines 35 - 48)	16	$ 22,492		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
See attached Schedule E			114,776
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,776

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 297,565
TOTAL (agree to Schedule V, line 17, col. 3)	$ 297,565
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Insurance & Annuity	401(k) administration	$ 225
Altschuler, Melvoin & Glasser LLP	Accounting	13,486
American Express Tax & Bus Srv	Accounting	5,926
Systematic Management	Consulting	5,742
Freidman, Anselmo & Lindberg	Collections	7,711
Holleb & Coff	Legal	903
Personnel Planners	U/C Consulting	762
James Samatas	Legal	50
Christine Toolan	Consulting	60
Doug Danenberger	Consulting	500
Royal Management Corp.	Web site development	338
See attached Schedule E		2,916
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 38,619

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,206
Unemployment Compensation Insurance	20,265
FICA Taxes	220,994
Employee Health Insurance	53,509
Employee Meals	9,385
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	10,073
Other Employee Benefits	7,257
TOTAL (agree to Schedule V, line 22, col.8)	$ 350,689

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,926
Health Care Worker Background Check	
(Indicate # of checks performed 52)	624
Miscellaneous dues & subscriptions	139
Miscellaneous licenses and permits	471
Allocated from Management Company	2,850
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,010

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,274
Allocated from Management Company	486
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,760

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred maintenance	7/98	$ 1,720	3 yrs	$	$ 287	$ 573	$ 573	$ 287	$	$	$	$
2	Painting & decorating	12/99	1,151	3 yrs			192	384	384	191			
3													
4													
5													
6													
7													
8													
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18													
19													
20	TOTALS		$ 2,871		$	$ 287	$ 765	$ 957	$ 671	$ 191	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,172** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **81,252**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,385** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **48**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.